Compassion in the emergency department. Part 2: barriers to the provision of compassionate care

Hunter, David James; McCallum, Jacqueline; Howes, Dora

Published in:
Emergency Nurse

DOI:
10.7748/en.2018.e1775

Publication date:
2021

Document Version
Author accepted manuscript

Compassion in the Emergency Department. Part 2: barriers to the provision of compassionate care.

Authors

Dr David J Hunter

School of Health, Nursing & Midwifery

University of the West of Scotland

Paisley, UK

david.hunter@uws.ac.uk

Dr Jacqueline McCallum

School of Health and Life Sciences

Glasgow Caledonian University

Glasgow, UK

Dr Dora Howes

School of Medicine, Dentistry and Nursing

University of Glasgow (Singapore)

Singapore

Abstract

In this second part of our three part series, David Hunter and colleagues discuss the barriers to the provision of compassionate care in the Emergency Department. Part one of the series reported on the doctoral level research, which explored the experiences of student nurses in the Emergency Department in relation to compassionate care. Many of the findings that emerged related to what the student nurses in the study considered as barriers to the

provision of compassionate care in this particular type of clinical environment. Six barriers to compassionate care were identified. This article considers them all in detail.

Keywords

Exploratory-Descriptive Qualitative Research, Student Experience, Compassionate Care, Emergency Department

Introduction

This article focuses on some of the findings of a qualitative research study which explored the experiences of student nurses, in the Emergency Department, in relation to compassionate care. The focus here is on what students considered to be barriers to the provision of compassionate care in this clinical setting. The underpinning methodology used is that of an exploratory-descriptive qualitative (EDQ) design, based upon the works of Sandelowski (2000, 2010) and Stebbins (2001). Following ethical approval, 15 students (year 1 = 5, year 2 = 5 and year 3 = 5), from across the West of Scotland, and who between them had been placed in 8 different Emergency Departments, participated in face-to-face semi-structured interviews. These were audio recorded and transcribed verbatim. Thematic data analysis was undertaken based upon the work of Braun and Clarke (2006). The students did not have any difficulty identifying what they considered the barriers to providing compassionate care to be, thereby highlighting the realities of current emergency nursing. Six barriers were identified and are elaborated upon in this article. Direct quotations are provided to illustrate some of the thoughts of the students who participated. The six barriers identified are:

- Alcohol and drug related presentations
- Mental health issues and aggression
- Regular attendees
- Physicality of the department
- Time and government targets
- Staffing levels

Alcohol and drug related presentations

The findings illuminated a recurring discussion with students regarding patients presenting with alcohol or drug related issues. This is unsurprising as 35% of all UK Emergency Department presentations may be alcohol related, increasing to 70% at peak times during the weekend (Currie et al., 2015). Presentations associated with recreational drug use were also explored by students. This topic is supported by a recent UK study of patients utilising emergency services due to recreational drug and alcohol use. The study by Archer et al. (2013), found that of those who attended the Emergency Department, 46% had used one or more recreational drugs with alcohol, 31% had drunk alcohol alone while 23% had used recreational drugs alone. During the discussion of this patient group, students reported that compassionate care had been lacking. There was the suggestion that staff perceived these patients as a nuisance or were dismissive of their reasons for attending the ED. Students also highlighted that patients who were intoxicated were less likely to be offered oral fluids or a blanket for comfort and warmth. Whilst students recognised the complexity of alcohol and drug misuse, they reported that nurses within the Emergency Department were

frustrated at having to care for such patients over others or that their attitudes towards these patients was less compassionate than others. Thomas exemplifies this feeling:

> *"You were getting people who were coming in just maybe drunk off the street... some of the staff seen them as a nuisance or just wanting them treated and gone."* (Thomas)

The experiences of the students in this study are mirrored in the literature. Warren et al. (2012) found that whilst emergency nurses and doctors agreed that intoxicated patients should be treated with respect, the reality differed, leading to a breakdown of compassionate care provision. Another study identified that of Emergency Department staff who participated (n=78), 85% felt that the patient's state of intoxication created a barrier to treatment delivery (Indig et al., 2009). Conversely, a study conducted with nurses from four wards in a large teaching hospital found that nurses held positive or at least neutral attitudes towards patients with alcohol problems (Crothers & Dorrian, 2011). One possible explanation for this could be that nurses working in the Emergency Department are dealing with patients who present with acute intoxication, and its associated issues such as verbal and physical abuse, whereas patients admitted to hospital wards will have either been injured whilst drunk or be living with an alcohol related condition such as liver cirrhosis. To support this, Ferns and Cork (2008a) highlighted the relationship between alcohol intoxication and aggression suggesting that the thought processes, responses and behaviours of patients would vary as a result of the physical and psychological effects of

consuming alcohol. They concluded by recognising the complexities around how best to manage alcohol related aggression in the Emergency Department (Ferns & Cork, 2008b).

Whilst students identified alcohol and drug related presentations as a barrier to compassionate care, they also provided positive examples, as described by Lucy:

> *"A lot of it comes down to substance misuse or alcohol misuse but there was one particular patient who had come in, on the flipside, who got really good compassionate care. She was in her 40s, she had a drink problem, em, she was referred to substance misuse nurses. They were so patient with her. She was really upset with herself. She was losing her family as a result of it and they did take the time, one of the doctors in particular was fantastic. He was really, really good."* (Lucy)

This could be an example where alcohol was the contributing factor to the admission, but as the patient was not disruptive she received compassionate care. A possible explanation to this patient encounter could be her age and gender which was supported in a study by Rolfe et al. (2006) who identified that, in patients who they defined as drinking heavily, aggressive behaviours were more likely if the patient was young and male.

Mental health issues and aggression

Intertwined with patients who presented with alcohol and drug related problems to the Emergency Department were those patients who had mental health issues or displayed aggression. Students saw similarities in the way this patient group were treated to those with alcohol or drug presentations. Delaforce and Dolan (2013, p. 212) define a psychiatric emergency as "any disturbance in the client's thoughts, feelings or actions for which immediate therapeutic intervention is necessary". They go on to highlight that emergency nurses dealing with a variety of life threatening situations on a regular basis may not recognise a mental health crisis as a true emergency (Delaforce & Dolan, 2013). The number of people presenting at the Emergency Department due to self harm or attempted suicide is significant, although exact figures are not recorded (Polling et al., 2015). Estimates suggest approximately 170,000 cases present to the Emergency Department each year in the UK (Jones & Avies-Jones, 2007). The students in this study highlighted that a barrier to the provision of compassionate care for patients presenting with mental health issues, particularly self-harm or suicidal ideation, came from the patients refusing help. They talked about nurses having a 'why bother' response after attempts to offer care were refused. Conlon and O'Tuathail (2012) highlighted that within the Emergency Department, the focus of care was on the physical injury, whereas self-harming patients were considered as being manipulative, attention seeking or beyond help. Nevertheless, an earlier study by McCann et al. (2006) found that emergency nurses held supportive attitudes towards patients who had self-harmed. The quote from Lucie highlights this:

> *"Some of the patients that were coming in, they were suicidal, some of them abusive, aggressive and it was quite difficult at times to try and provide that sort of care*

[compassionate care] for them when they didn't themselves really want to be receiving [it]..." (Lucie)

Another significant issue within the Emergency Department, which acts as a barrier to compassionate care is aggression (Tan et al., 2015). Students in this study made clear links between alcohol and drug related presentations, and some mental health patients, with aggressive behaviours. This was also captured by Lucie:

"Patients coming in with alcohol excess, with falls and injuries but were still quite intoxicated and were quite aggressive at times, that was quite tough." (Lucie)

This is supported in the literature with Gilchrist et al. (2011) highlighting that alcohol is regularly identified by Emergency Department staff as being the primary cause of aggressive or violent incidents. Students also recognised that violence and aggression could occur without these factors, such as when a relative receives bad news. However the overwhelming cause cited by the students related to alcohol, drugs and/or mental health issues. The literature suggests that violence and aggression in the Emergency Department is under-reported (Neades, 2013, McLaughlin et al., 2009). This is partly because nurses may perceive it to be part of the job (McLaughlin et al., 2009, Tan et al., 2015), but they may also be reluctant to report incidences out of a sense of duty to the patient and as a way of appearing compassionate (Powley, 2013). In addition, students recognised their own limitations when it came to providing care to patients with mental health issues. They suggested that a lack of previous exposure to patients with mental health concerns inhibited

their ability to provide compassionate care in the Emergency Department to this patient group. Barrett and Jackson (2013) recognised that there is a need for adult student nurses to be educated and prepared to support the needs of mental health patients and that adult nurses will encounter patients whose physical health has been influenced by their mental health. The Emergency Department is one such environment where patients whose presentation may be related to a mental health issue will be predominately cared for by adult registered nurses.

Regular attendees

Another patient group the students discussed in relation to challenging the provision of compassionate care was those who regularly attended the Emergency Department. A range of terminology is used colloquially to describe this patient group and includes: 'regular attender', 'regular', 'frequent attender' 'frequent flier' and 'repeater' (Baston, 2005). In this study, students used terms such as 'regular attender' or 'frequent attender', although one student did quote nurses using the term 'repeat offender' with such patients. The students made links between patients who attended regularly and those who had mental health, drug or alcohol issues, seeing these as causative factors for the frequent visits.

> *"They [the staff] call them "the regulars". If it was someone like that who had come in, I don't feel the staff would... they weren't as compassionate to them as they would have been to another patient."* (Danielle)

Regular attendees represent approximately 5% of all patients who attend the Emergency Department and yet account for 21-28% of all visits and associated costs (Soril et al., 2016). Bergman (2012) identified feelings of frustration from nurses regarding regular attendees. Similarly, Fry (2012) and Hillman (2014) identified that nurses made judgements regarding the worthiness of patients who attended the Emergency Department. Patients who breached nurses' ideas of worthiness engendered feelings of resentment and could experience negative consequences such as an increase in waiting time for treatment (McConnell et al., 2016). An alternative consequence could be the reduced provision of compassionate care as exemplified by Danielle's quotation. However, two students highlighted alternative regular attendees. These were patients they had seen before in the Emergency Department, with chronic conditions, who were en route to another care setting. In this instance, familiarity between the student and the patient acted to promote compassionate care, as illustrated by Leeanne's comment:

> *"Like you see one person coming in and say we've [they've] got urology problems so they are a frequent... and I don't know the right words to say, but they are [a] frequent patient in A&E because that is the way they can only get admitted to the Ward."* (Leeanne)

Physicality of the department

The physicality of the department was highlighted by students as having a detrimental effect on their ability to provide compassionate care to patients and their families. The lack of available cubicles was discussed with students expressing concern that patients were

often left in corridors in pain, vomiting or exposed. Issues with equipment were also considered as being a barrier to the provision of compassionate care.

> *"The setup with the cubicles and things isn't always the greatest. Em, or even silly things like the trolleys don't... the height, it doesn't really go, they don't go down very far. So if you are a wee buddy with stiff hips it is really difficult to get on and off."* (Katrina)

The concerns raised by students in this study mirror the findings from the study by Person et al. (2013) where participants expressed concerns about patients being on stretchers in the corridors along with space limitations and issues with equipment and technology. Timmins et al. (2014) also provide an example of where emergency nurses attempted to provide compassionate care to their patients, but due to a lack of basic equipment, in this case pillows, were prevented from doing so. Research into the patient experience of the Emergency Department has criticised the care environment, with uncomfortable trolleys frequently being cited (Gordon et al., 2010). Walsh and Knott (2010) found that patients ranked the cleanliness of the department, the comfort of trolleys and the use of modern equipment as being highly important to them. One student in this study highlighted the lack of available cubicles, as well as the competing demands from different specialities for space to assess patients who had been referred to them, as barriers to compassionate care.

"People on corridors and moving people out to move people in to get assessed and then back out. That's just horrendous. I would hate to be sick there, lying in a corridor where people can walk by and see that, and it's sick the way... writhing about in pain or vomiting and, or having bits exposed because you're moving about that don't need to be and I think that's just, it's not very pleasant." (Ellie)

Ellie also highlighted the negative affects this appeared to have on staff. Hamilton et al. (2013) recognise this phenomenon and suggest that staff can feel frustrated and disempowered as a result.

Time and government targets

One of the major findings of this study centres around the impact of time. The majority of students (n=14) discussed it and specifically identified a lack of time as a barrier to the provision of compassionate care. This mirrors the findings of Curtis et al. (2012) where student nurses identified that having time to spend with patients is central to the ability to provide compassionate care. In this study, students suggested that nurses in the Emergency Department did not have the time to spend with their patients to provide compassionate care, as they were required to move quickly from one patient to the next.

"Lack of time is a definite big barrier to compassion... I think a nurse wants to be able to spend more time with their patients and that then would allow them to deliver compassion." (Robert)

Gallagher et al. (2014) identified that lack of time was a significant factor that prevented nurses from providing quality nursing care to older adults in the Emergency Department. Competing acute care priorities were also identified and this caused frustration from the nurses as they felt they could not deliver the care they wanted to (Gallagher et al., 2014). Enns and Sawatzky (2016) also found that nurses were concerned that the lack of available time to spend with patients as it resulted in only minimal levels of care being provided. However, students in this study did recognise that it was important to maximise the time that was available with patients to foster the provision of compassionate care.

As highlighted in Part 1, students suggested that the building of relationships with patients, and their loved ones, was central to the provision of compassionate care. From an Emergency Department point of view, a consequence of having limited time with patients was that the relationships students could forge with them was described as superficial. Rios-Risquez and Garcia-Izquierdo (2016) suggest that the short-term nature of the interaction between the Emergency Department nurses and their patients could lead to a lower level of emotional involvement on the part of the nurses. Emergency Department nurses have also expressed concerns that due to the nature of the environment, patients are at risk of being "lost in the system" (Enns & Sawatzky, 2016). McConnell et al. (2016) recognise that the challenges of patient throughput, and a focus on tasks and interventions in the Emergency Department, do result in fragmented care delivery and staff being unable to fully engage with their patients. One possible explanation for these superficial relationships may be due to the nature of emergency nursing itself. Although a little dated, an American study found

that registered nurses in the Emergency Department spent 25.6% of their time delivering direct patient care compared to 48.4% performing indirect patient care (Hobgood et al., 2005). An additional finding of Hobgood et al.'s (2005) study was that these percentages were nearly constant regardless of the workload of the department.

Another element which students identified as a barrier to the provision of compassionate care, and which links with the notion of time, was the impact of the UK/Scottish Government's policy (Department of Health, 2000, Scottish Government, 2007) of having patients discharged, admitted or transferred from the Emergency Department within four hours of their arrival. Students expressed their concerns that four hours was insufficient in some cases to assess patients, perform investigations and make a diagnosis and treatment plan. Mortimore and Cooper (2007) previously found that emergency nurses were concerned that the four hour target was compromising the quality of care provided and that the focus on meeting the target was shifting priority away from clinical need, limiting communication and treatment contact with patients. Hoyle and Grant (2015) identified similar findings. These included nurses expressing concerns that the four hour target had resulted in there being less time available to care for the sickest patients and that care was sometimes compromised to meet the target (Hoyle & Grant, 2015).

> *"This four-hour time limit. Em, personally I think is a joke, like to come in, to tell your symptoms, to see how quickly you get on the queue of priorities, to then, em, get your blood test results back and if you're getting kept in, staying home, those four hours are not long enough to deliver what you need to do."* (Leeanne)

Students also commented on the media portrayal of the four hour target. One possible explanation of this finding is the high degree of interest on the target, which the media brought to the attention of the public, in the wake of the serious concerns regarding care and treatment at Mid-Staffordshire NHS Foundation Trust (Hoyle & Grant, 2015).

The final aspect of time discussed by the students, was that of bed management. Students suggested that the staff in the Emergency Department were often blamed, or faced criticism from the public and media, regarding patients waiting longer than the four hour target when these issues were that of wider bed management. Equally, they had witnessed bed managers in the Emergency Department attempting to improve patient flow. The role of the bed manager is known to be complex and stressful, as the nurses employed in this capacity deal with internal and external factors while juggling competing demands for resources (Proudlove et al., 2007). Proudlove et al. (2007) also raised the importance of good working relationships between bed managers and the nurses they interact with. In this study, students identified the bed manager as someone who actively interacted with the nurses in the Emergency Department and other clinical areas to improve the patient experience, thereby confirming Proudlove et al.'s (2007) findings.

Staffing levels

The final barrier to compassionate care students in this study identified and discussed was around staffing levels. Almost half of the students who took part commented on the

negative impact that poor staffing had on the delivery of compassionate care. Inadequate staffing levels have been shown as linked to poor care provision (Francis, 2013). The National Institute for Health and Care Excellence (NICE) (2014) have published guidelines regarding safe staffing for nursing within adult acute in-patient wards. The guideline recognises that there is no single correct staff to patient ratio, which can be applied to all wards and therefore it is the responsibility of each area to calculate their own staffing requirements to ensure safe patient care (NICE, 2014). This is also true in the Emergency Department. An audit conducted by Wise et al. (2015) concluded that guaranteed minimum staffing numbers were required but with flexibility to alter in response to patient need. Wise et al. (2015) do not make any recommendations regarding what should be considered as guaranteed minimum staffing levels, but they do suggest the need for further research to explore any links which may exist between Emergency Department staffing levels and patient outcomes.

From the student perspective, issues with staffing numbers in the Emergency Department manifested themselves by impacting on their supernumerary status. Another consequence was that being short staffed resulted in the students having less time to spend with patients to provide compassionate care, as described by Lucie:

> *"Not enough staff. When you go in for a shift and you are meant to be supernumerary, but you're trying to do the job of maybe a clinical support worker because they're short staffed that day and you've not got the time that you would normally have to spend with your patients, making sure they've got, you know, a*

glass of water or got an extra blanket or things like that. That was quite tough." (Lucie)

It is recognised that students often have to negotiate how to be supernumerary in each clinical area (Allan et al., 2011). Elcock et al. (2007) suggest that students are willing to sacrifice their learning needs in order to be seen as part of the clinical team and to pass their assessment in practice.

Shepherd and Uren (2014) emphasise that there is a risk of students providing unsupervised care when their ability to do so may not have been assessed if their supernumerary status is not protected. In addition, supernumerary status can be seen to support mentors as it allows them to focus on student learning rather than supervising an apprentice and aids in the assessment process as the student develops (Shepherd & Uren, 2014).

Adding to staffing levels and the interruption to supernumerary status, students discussed their belief that Emergency Departments required dedicated staff to deal with patients with mental health issues. This linked to their discussion around the care offered to this client group and their general concerns that patients with mental health issues were offered less compassion than those with a physical illness or injury. Students reported feelings of distress and concern that patients with mental health presentations, such as self-harm or suicidal ideation, were leaving the department still at risk of further harm. Although limited, the literature does support the presence of mental health nurses within the Emergency Department. Having mental health liaison nurses based within an Emergency Department

has also been shown to make emergency nurses feel more supported and confident when caring for patient with mental health issues (Waghorn, 2010).

Conclusion

Students identified and described six distinct barriers, which impacted the provision of compassionate care within the Emergency Department. None of the barriers identified by the students in this study were surprising. The findings are reflected in the literature. Nevertheless, what this study adds is the students' experiences of encountering the various barriers. This includes the notion that the barriers are not always clear cut and at times, the students overcame them or witnessed the Emergency Department staff finding a way to provide compassionate care, despite them.

References

Allan, H. T., Smith, P. & O'Driscoll, M., 2011. Experiences of supernumerary status and the hidden curriculum in nursing: a new twist in the theory-practice gap? *Journal of Clinical Nursing,* 20(5/6), pp. 847-855.

Archer, J. R. H., Dargan, P. I., Wood, D. M. & Winstock, A. R., 2013. Hospital and prehospital emergency service utilisation as an impact of acute recreational drug and ethanol toxicity. *Journal of Substance Use.* 18(2), pp. 129-137.

Barrett, P. & Jackson, A., 2013. Swimming without the water: a critical perspective on mental health experience for adult nursing students. *Nurse Education in Practice.* 13(6), pp. 487-491.

Baston, S., 2005. Regular attenders at A&E. *Emergency Nurse.* 13(5), pp. 20-22.

Bergman, C. L., 2012. Emergency nurses' perceived barriers to demonstrating caring when managing adult patients' pain. *Journal of Emergency Nursing.* 38(3), pp. 218-225.

Braun, V. & Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology.* 3(2), pp. 77-101.

Conlon, M. & O'Tuathail, C., 2012. Measuring emergency department nurses' attitudes towards deliberate self-harm using the Self-Harm Antipathy Scale. *International Emergency Nursing.* 20(1), pp. 3-13.

Crothers, C. E. & Dorrian, J., 2011. Determinants of nurses' attitudes towards the care of patients with alcohol problems. *ISRN Nursing.* pp. 1-11.

Currie, C., Davies, A., Blunt, I., Ariti, C. & Bardsley, M., 2015. *Alcohol-specific activity in hospitals in England.* London: Nuffield Trust.

Curtis, K., Horton, K. & Smith, P., 2012. Student nurse socialisation in compassionate practice: a grounded theory study. *Nurse Education Today.* 32(7), pp. 790-795.

Delaforce, C. & Dolan, B., 2013. Mental health emergencies. In: Dolan, B. & Holt, L. eds. *Accident & Emergency: theory into practice.* 3rd edition. Edinburgh: Bailliere Tindall Elsevier, pp. 211-226.

Department Of Health. 2000. *The NHS Plan. A plan for investment. A plan for reform.* London: The Stationary Office.

Elcock, K., Curtis, P. & Sharples, K., 2007. Supernumerary status - an unrealised ideal. *Nurse Education in Practice.* 7(1), pp. 4-10.

Enns, C. L. & Sawatzky, J. V., 2016. Emergency nurses' perspectives: factors affecting caring. *Journal of Emergency Nursing.* 42(3), pp. 240-245.

Ferns, T. & Cork, A., 2008a. Managing alcohol related aggression in the emergency department (part 1). *International Emergency Nursing.* 16(1), pp. 43-47.

Ferns, T. & Cork, A., 2008b. Managing alcohol related aggression in the emergency department (part 2). *International Emergency Nursing.* 16(2), pp. 88-93.

Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*. London: The Stationary Office.

Fry, M., 2012. An ethnography: understanding emergency nurses practice belief systems. *International Emergency Nursing.* 20(3), pp. 120-125.

Gallagher, R., Fry, M., Chenoweth, L., Gallagher, P. & Stein-Parbury, J., 2014. Emergency department nurses' perceptions and experiences of providing care for older people. *Nursing & Health Sciences.* 16(4), pp. 449-453.

Gilchrist, H., Jones, S. C. & Barrie, L., 2011. Experiences of emergency department staff: Alcohol-related and other violence and aggression. *Australasian Emergency Nursing Journal.* 14(1), pp. 9-16.

Gordon, J., Sheppard, L. A. & Anaf, S., 2010. The patient experience in the emergency department: a systematic synthesis of qualitative research. *International Emergency Nursing.* 18(2), pp. 80-88.

Hamilton, R., Dolan, B. & Ardagh, M., 2013. Creating patient flow. In: Dolan, B. & Holt, L. eds. *Accident & Emergency: theory into practice.* 3rd ed. Edinburgh: Bailliere Tindall Elsevier, pp. 577-586.

Hillman, A., 2014. 'Why must I wait?' The performance of legitimacy in a hospital emergency department. *Sociology of Health & Illness.* 36(4), pp. 485-499.

Hobgood, C., Villani, J. & Quattlebaum, R., 2005. Impact of emergency department volume on registered nurse time at the bedside. *Annals of Emergency Medicine.* 46(6), pp. 481-489.

Hoyle, L. & Grant, A., 2015. Treatment targets in emergency departments: nurses' views of how they affect clinical practice. *Journal of Clinical Nursing.* 24(15/16), pp. 2211-2218.

Indig, D., Copeland, J., Conigrave, K. M. & Rotenko, I., 2009. Attitudes and beliefs of emergency department staff regarding alcohol related presentations. *International Emergency Nursing.* 17(1), 23-30.

Jones, R. & Avies-Jones, A., 2007. An audit of the NICE self-harm guidelines at a local accident and emergency department in North Wales. *Accident and Emergency Nursing.* 15(4), pp. 217-222.

McCann, T., Clark, E., McConnachie, S. & Harvey, I., 2006. Accident and emergency nurses' attitudes towards patients who self-harm. *Accident and Emergency Nursing.* 14(1), pp. 4-10.

McConnell, D., McCance, T. & Melby, V., 2016. Exploring person-centredness in emergency departments: a literature review. *International Emergency Nursing.* 26, pp. 38-46.

McLaughlin, S., Gorley, L. & Moseley, L., 2009. The prevalence of verbal aggression against nurses. *British Journal of Nursing.* 18(12), pp. 735-739.

Mortimore, A. & Cooper, S., 2007. The "4 hour target": emergency nurses' views. *Emergency Medicine Journal.* 24(6), pp. 402-404.

National Institute for Health and Clinical Excellence (NICE). 2014. *Safe staffing for nursing in adult inpatient wards in acute hospitals.* Manchester: National Institute for Health and Clinical Excellence.

Neades, B., 2013. Aggression. In: Dolan, B. & Holt, L. eds. *Accident & Emergency: theory into practice.* 3rd ed. Edinburgh: Bailliere Tindall Elsevier, pp. 183-189.

Person, J., Spiva, L. & Hart, P., 2013. The culture or an emergency department: an ethnographic study. *International Emergency Nursing.* 21(4), pp. 222-227.

Polling, C., Tulloch, A., Banerjee, S., Cross, S. Dutta, R., Wood, D. M., Dargan, P.I. & Hotopf, M., 2015. Using routine clinical and administrative data to produce a dataset of attendances at Emergency Departments following self-harm. *BMC Emergency Medicine* [online]. 15(15), pp. 1-8. [viewed 7 June 2017]. Available from: http://bmcemergmed.biomedcentral.com/articles/10.1186/s12873-015-0041-6

Powley, D., 2013. Reducing violence and aggression in the emergency department. *Emergency Nurse.* 21(4), pp. 26-29.

Proudlove, N., Boaden, R. & Jorgensen, J., 2007. Developing bed managers: the why and the how. *Journal of Nursing Management.* 15(1), pp. 34-42.

Rios-Risquez, M. I. & Garcia-Izquierdo, M., 2016. Patient satisfaction, stress and burnout in nursing personnel in emergency departments: a cross-sectional study. *International Journal of Nursing Studies.* 59, pp. 60-67.

Rolfe, A., Dalton, S., Krishnan, M., Orford, J., Mehdikhani, M., Cawley, J. & Ferrins-Brown, M., 2006. Alcohol, gender, aggression and violence: findings from the Birmingham Untreated Heavy Drinkers Project. *Journal of Substance Use.* 11(5), pp. 343-358.

Sandelowski, M., 2010. What's in a name? qualitative description revisited. *Research in Nursing & Health.* 33(1), pp. 77-84.

Sandelowski, M., 2000. Whatever happened to qualitative description? *Research in Nursing & Health.* 23(4), pp. 334-340.

Scottish Government. 2007. *Better health, better care: action plan.* Edinburgh: Scottish Government.

Shepherd, P. & Uren, C., 2014. Protecting students' supernumerary status. *Nursing Times.* 110(20), pp. 18-20.

Soril, L. J. J., Leggett, L. E., Lorenzetti, D. L., Noseworthy, T. W. & Clement, F. M., 2016. Characteristics of frequent users of the emergency department in the general adult population: a systematic review of international healthcare systems. *Health Policy.* 120(5), pp. 452-461.

Stebbins, R. A., 2001. *Exploratory research in the social sciences.* London: Sage Publications Ltd.

Tan, M. E., Lopez, V. & Cleary, M., 2015. Nursing management of aggression in a Singapore emergency department: a qualitative study. *Nursing & Health Sciences.* 17(3), pp. 307-312.

Timmins, F., McBennett, P. & Norton, C., 2014. Providing compassionate care to patients on Emergency Department trolleys: can we do more? *Nursing in Critical Care.* 19(3), pp. 114-116.

Waghorn, J., 2010. The impact of basing mental health liaison nurses in an emergency department at night. *Journal of Psychiatric and Mental Health Nursing.* 17(7), pp. 647-650.

Walsh, M. & Knott, J. C., 2010. Satisfaction with the emergency department environment decreases with length of stay. *Emergency Medicine Journal.* 27(11), pp. 821-828.

Warren, O. U., Sena, V., Choo, E. & Machan, J., 2012. Emergency physicians' and nurses' attitudes towards alcohol-intoxicated patients. *The Journal of Emergency Medicine.* 43(6), pp. 1167-1174.

Wise, S., Fry, M., Duffield, C., Roche, M. & Buchanan, J., 2015. Ratios and nurse staffing: the vexed case of emergency departments. *Australasian Emergency Nursing Journal.* 18(1), pp. 49-55.